



# Indian Speech and Hearing Association

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## Padmashree Prof S. Kameswaran Endowment Oration

41<sup>st</sup> ISHACON Pune 2009

Dr. M.N Nagaraja

Respected Teachers, Beloved students, Fellow professionals, Ladies and Gentlemen :

At the outset I express my heartfelt thanks to ISHA for bestowing me with the Padmashree Dr. Kameswaran's oration at the 41<sup>st</sup> ISHACON 2009. Professor Kameshwaran is one of the icons in nurturing the field of Speech and Hearing during its natal and post-natal periods and continued his contributions to the growth of the field at all stages. I humbly accept this prestigious oration with all humility. It gives me immense pleasure to present the oration to this august gathering of 41<sup>st</sup> ISHACON 2009. It is particularly gratifying to note that the nomination has come around my 60<sup>th</sup> birthday. With this nomination, I believe that I have a lot more to work for the betterment of persons with disability, our profession and my fellow colleagues.

I am one of the few privileged to have the equal opportunity to serve as Audiologist & Speech Language Pathologist in Government as well as Non Government Organizations (NGO) and probably the only one to have worked with three apex institutions viz., All India Institute of Medical Sciences, New Delhi (from 1975-79), National Institute of Mental Health and Neuro Sciences, Bangalore (from 1979-86) and Ali Yavar Jung National Institute of Hearing Handicapped (from 1986-2003). The Speech pathology and Audiology department then at both AIIMS and NIMHANS were in their formative years, and AYJNIHH was in the early years of its establishment.

Lots have been said about the growth of speech and hearing profession in India. The field has a history of around 45 years. The development of the field in the first 25 years has been documented in the publication edited by Prof. N. Ratna brought out during the Silver jubilee conference of ISHA in Bangalore in 1993. Similarly two publications that is Status of Disability 2000 and 2003 have significant facts about hearing and speech handicap, legislations, education, vocation and other aspects of rehabilitation. However, very less has been talked about professional standards and its auditing.

In the early seventies only two institutions were engaged in training of graduates and postgraduates in speech and hearing. At that time, the debate was mainly on adequacy and type of clinical exposure in terms of variety and numbers. One among them i.e. All India Institute of Speech and Hearing (AIISH), Mysore had a non-hospital based institutional approach to practicum/clinical exposure. Thus advantage of learning from bed side testing of inpatients, pre- post surgical assessment, observation of non speech & hearing diagnostic procedures, interaction with medical & other paramedics as a member of the team etc was less possible to them. The other institution i.e. BYL Nair hospital, Mumbai, although had the privileges of medical set-up had limited emphasis on allied subjects (psychology, psychometry and exposure to behavior modification techniques etc). In

spite of these differences, both courses co-existed as fairly well matched programs. Both institutions over a period of time built up the required special educational/school or pre-school backup facility. During the same period the number of graduates and post graduates passing out were limited and so also were the opportunities & job availability. The pass percentage was always high. Because of the limited number of available jobs, majority of trained graduates and post graduates had to seek employment away from their place of origin. This resulted in the local language becoming a possible barrier in rendering therapeutic services. Remunerations in these jobs were also not compatible to our professional qualification or to any other non-medical technical degrees. It should be stressed that in spite of these problems, a majority of them earned a good name in the places they have served. This may be attributed to the presence of very good, dedicated and committed teachers at the graduate/postgraduate courses who not only took interest to teach the assigned subjects but also stressed on services to clients, good practice ethics and nationalism. Our teachers use to imbibe these qualities in us and advised us to always consider remuneration as secondary.

In the present scenario, a trained graduate or postgraduate no longer needs to search for employment. They are recruited even before the results of their final year examination are announced. Although there are currently around 32 institutions conducting graduation courses and 15 of them offering post graduate courses, smaller centers and centers located in townships and semi urban or rural places hardly get any trained graduates or post graduates for appointments. Even though the number of passing out students have escalated by many folds in comparison to what it used to be in the early eighties, there are not many candidates to even fill the existing vacant posts even at their own institutions of training. Therefore, although many institutions have sprung up to train speech & hearing professionals in recent past, the biggest problem faced by NGO and even government. institutions continue to be the non availability of enough trained manpower / professional to take up appointments.

During my tenure as officiating director of AYJNIHH in the year 2000-01, I had to take steps to provide manpower for starting District Disability Rehabilitation Centers (DDRC) under National Program for Rehabilitation of Disabled persons (NPRPD). Nine DDRC centers in five states under AYJNIHH were started and thus provided needed manpower in speech and hearing by introducing compulsory internship for the first time in the country with postings of interns at DDRC and other centers. This gave an opportunity for the interns to know the dismal condition that exists in rural and semi urban places, which made the internees to be more empathetic with clients and develop methods to provide quality services within the limited infrastructure. Later the concept of internship was taken up by RCI and made compulsory part of the syllabus at the graduate course from 2002 onwards. This has resulted in acquiring better skills, broadening of knowledge, clinical experience, multidisciplinary interaction, special educational needs and corporate experience to the professionals in the making.

Recently, AIISH Mysore, I hear has introduced compulsory service of one year after post graduation at AIISH and its study centers. This became possible for AIISH, as it is a stipendiary institute. May be all private and NGO run institutions need to brainstorm on this issue. In order to have more number of graduates and postgraduates becoming available to reach the needy as well as to offset manpower requirements of the institutions it may be prudent on the part of RCI and such other authorities to enhance training period by including rural and semi urban postings as a compulsory part of post graduate training.

Institutions have very less options to retain their trained post graduate students and have to be

coaxed with better incentives. Only government institutes may sometimes be able to retain them. The most probable reason for this problem of non-availability of trained persons is the financial constraints and inability of Indian Institutions to remunerate at par with foreign placements and Indian hearing Industries. However, remunerative efforts need not always be in terms of monetary benefit alone. It could be result oriented incentives like additional allowances for acquiring higher qualifications, attending/participating/conducting seminars and workshops, taking up additional clinical or research responsibilities, coordinating exam related activities, publication in national and international journals. These can be assessed at regular intervals and made as performance-based incentives. This type of performance based incentive as well as performance based promotion schemes incorporated in a few institutions needs to be understood and incorporated by the rest of institutions after proper debate and discussion in appropriate forums of ISHA, RCI etc.

Till the mid eighties, there were only three to five institutions offering courses. Thus the number of applicants applying for the courses at different institutions were always more than the number of seats available. This resulted in the institutions being able to choose amongst the applicants in both the merit and reservation categories. Now, in view of the large number of institutions that have sprung up/available, the ratio between the numbers of applicants to the number of seats has come down and there is no choice in terms of selection of candidates to the courses. Many NGO training institutions are not able to fill up their available intake. This scenario in the NGO sector may be due to high fee structure and at times poor infrastructure. Poor awareness amongst the general students about our course, as well as its low professional image compared to engineering, medicine and other well-known courses is also a point of concern to all of us running the training institutions. The major national institutions can still attract good students because of their stature as government organizations and low subsidized fee structure apart from the infrastructure and experienced academic faculty available with them.

The quality, standard and the professional image of our courses need to be enhanced. The issue of attracting meritorious and well-motivated candidates to our course needs to be addressed by all concerned.

The increase in number of colleges and institutions engaged in the training of professionals has really not resulted in providing better quality of trained qualified audiologists or speech language pathologists or improved the quality of training. Except for a few non-government organizations that already existed as clinical service providers or as educational institutions, rest of the new institutions started had to develop clinics to provide practicum. Majority among them neither had the know-how to establish a clinical facility nor had a good tie-up with hospital facilities for practical exposure to their students. Many amongst them could not even tag with the right medical professionals who could identify and refer cases for evaluation and therapy. Many of us who are inspectors for RCI for evaluating and recommending institutions with regard to minimum requirement for starting a course have first hand experience of the dismal status of some of these institutions.

This situation may mainly be the result of professional failure to impress upon the management about the basic aims and objectives of the course. We may probably have failed to impress upon them that our course is mainly designed to produce clinical expertise to deal persons with communicatively impaired and thus the course is clinically intensive. Most of the time our courses are run by already established institutions conducting other courses like engineering/ dental/ nursing

B. Ed/ M. Ed etc, and for them it is yet another course. In some cases the principal or directors who head other programmes are entrusted to take care of speech and hearing courses even though they have no knowledge about the field. In few instances, parents of the special HI/MR children are made in charge of the courses as principal or director. Though intentions are well grounded, the key personnel running these institutions may not be in a position to appreciate the infrastructure needs of the speech & hearing courses from its wider perspective. More often the focus would be on a single condition or disability. Thus, the chances of clients of various types of speech and hearing disability spanning across a wide age range from infant to geriatric are often limited. Clients referrals from E.N.T specialists, Pediatricians, Neurologists, Psychiatrists and general practitioners also get restricted due to the nature and quality of the institution. Added to this many a time even the location and accessibility of the clinical facility situated away from the city may make it difficult for referred patients.

Majority of new colleges have purchased most of the advanced equipment, neither have the trained professionals to use them nor have the clientele on whom which can be utilized to and demonstrate it to the trainees. Many of the instruments often remain out of calibration and students may not even be aware of it. This has further resulted in a majority of post graduates, trained under such restricted environment becoming faculty for their junior batches without having the necessary clinical exposure and competence to evaluation, diagnosis, therapeutic interventions & fitment of aids and proper use of appliances. Further, they hardly have any exposure to teaching methods including critical evaluation of research articles published in journals due to lack of supervised exposure by senior staff during their course/training periods. Generally reading notes in the classroom becomes a lecture. Therefore I feel starting many institutions without having adequate staff with strong academic and clinical background would not result in bridging the gap of non-availability of manpower or improving the quality of training or providing excellent services to the needy.

At post graduate level, the training stresses not only on clinical facility for practicum but also for meeting dissertation guidance requirements of students as well. However in many approved colleges neither has the clinical facility in terms of variety or numbers nor approved faculty to guide. Thus we may have to rethink on the necessity of making our M.Sc courses dissertation based. It could be non-dissertation based PG programme as well.

In early 1990's, I was entrusted by ISHA to write a chapter each on special speech tests and Impedance Audiometry. A questionnaire was sent to several institutions as well as individual practitioners seeking information on speech materials developed and in use, procedures adopted for testing including masking for speech, calibration and differential diagnostics measures. Only 22 replies were received out of 112 contacted. Further, most Audiologists in ENT set-ups and private practice said that they seldom conduct masking and speech audiometry. Most of them stated the reasons for the same to be paucity of time due to heavy clinical load, availability of only partially sound treated cubicle and no single or double soundproof room facility. This seems to have not changed even now as per the feedback that I could gather and discussions that I had with my students and professional colleagues at various occasions. This reflects the clinical practice status in our country.

I need not have to stress the importance of the routine clinical tests that are to be carried out or on

speech tests here. However, in an era where more evidence based differential auditory test information is becoming available, one should not ignore to conduct or neglect primary basic tests and information that they provide. If a person is found to have normal or near normal sensitivity or threshold and passed off without carrying out routine speech tests, the possibility of that person having CAPD or auditory neuropathy would be missed. Children who have not been benefited with the most appropriate amplification and rigorous audition training have been found to have aplasia or Mondini. Thus, interdisciplinary interaction is the key factor in expanding the professional knowledge and skills.

Similarly hearing aid selection and fitting - specifically relating to counseling part is largely ignored. The hearing aid counseling in most situations today is centered on the product information and invariably restricted to technology and product pricing but hardly on the way in which a particular hearing aid is going to assist the client in hearing better within the functional limitations of his/her auditory system. The client starts using the aid with a false belief that his/her problem related to hearing would get completely resolved with the hearing aid. Very soon, the client begins to feel disappointed and slowly stops using it. Such a scenario may further lead to a court case. Ultimately the very goal of auditory rehabilitation suffers. Exposing the hearing impaired to the variety of amplification devices and their limitations is essential. Counseling should focus on the functional limitation of the hearing structure of the impaired and what amplification could do for him. Hearing aids and even cochlear implant may not provide solutions in many children. For them sign language or total communication could be the only plausible approach. In this connection, at AYJNIHH a sign language cell was established and three levels of sign language interpreter training course were introduced during 2000-01. This course was later recognized and approved by RCI and implemented at ISH- Bangalore and Sri Ramakrishna Mission Institute at Coimbatore. A serious discussion and deliberation on appropriate approaches to education of children with hearing impairment is now warranted. Further, we as professionals should insist on better definition of hearing handicap to make it more inclusive from what it is today.

Only in a few institutions, irrespective of they being Government funded or trust there appears to be some academic accountability such as students appraisal of teachers, exposure of students to well known experts in the profession, conducting clinical conferences on regular basis, journal clubs, publications of news letters, holding seminars on varied topics and exposing students to in-depth information, encouraging them to write papers and attend conferences, conducting summer workshops on teaching methodology manual preparation- practicum exposure aspects etc. In many institutions it may be far reached.

Therefore, though the training is conducted by all, based on the RCI prescribed/developed syllabi, neither there is uniformity in training offered nor control of professional auditing and accountability on the methods of teaching subjects in theory and quality as well as quantity of exposure to clinical practices. Though our courses have earned equivalence to western courses on paper and our postgraduates can find placement and higher education admissions at the developed west, still majority of students lack teaching, clinical and research skills.

There is a dire need to address this problem of quality of training programmes. Here are some suggestions;

a) RCI should not only be taking up the responsibility of inspecting and getting satisfied with the minimum criteria required to be met for starting training programs but also find ways and means to monitor the program. Better accountability should be built up on the terms on which permissions is being granted to start a new programme.

B) Inter institute co-operation has to be strengthened for holding seminars, Joint lectures, videoconferences and tele-demo. Clinical assessments and therapeutic interventions should be made available from the haves to have-nots, of course not at free of cost.

C) Common library in the geographical locality for journals and books may be considered along with the library of their own. Institutions also can build themselves on e-library to help their students.

d) Emphasis should be on practical exposure. As programme increases in its complexity the depth of information should be broadened. Diploma and graduate programs should have more of practical experiences and Postgraduate courses should have more in-depth theoretical and research knowledge.

e) There is hardly any track of work/research carried out in India. There is a need to pool this information at all India level. This would help the researchers to avoid duplication and develop more refined research method, incorporate local sociolinguistic and cultural factors and adopt several such key research issues.

f) UGC pattern of seminars and workshops for junior staff on teaching methodology in speech and hearing and clinical exposure and monitoring techniques have to be held periodically and attending them made compulsory once in every two years till ten years of service.

g) Publication of journal articles, student's appraisal of teachers, audit on number of topics and hours covered on theory and practicum should become basis for the evaluation of teaching and clinical supervisory staff.

h) ISHA should be given the responsibility of constituting National Examination Board for

- i) Common clinical competence examination
- ii) Common entrance test for at least post graduation courses
- iii) Entry level subject wise examination for becoming junior level lecturer
- iv) Uniformity in graduate and postgraduate examination pattern

i) An examination at the end of internship to assess minimum practical clinical abilities acquired by the graduate trainee should be conducted to keep up the clinical efficiency of the students.

I have spelt out my thoughts. I am aware of the Herculean task involved in revamping the human resource training and its ramifications. Somewhere, beginning has to be made and we are already at it. What is further required is the conglomeration of our human resources, knowledge, skills and experiences to build a brighter, mightier and vibrant field of ours for a better tomorrow.

Thank you all for your patient listening.

Jai Hind.